DEVELOPING AND IMPLEMENTING AN HIV/AIDS PLAN AT DISTRICT LEVEL

Department of Health

The EQUITY Project

The EQUITY Project, South Africa Nursing Council Building
3rd Floor, 602 Pretorius Street, Arcadia, Pretoria
PO Box 40394, Arcadia, 0007, South Africa

Telephone: +27 (0) 12 344 6117
Facsimile: +27 (0) 12 344 6115
Email: publications@equityproject.co.za
Website: www.equityproject.co.za

JULY 2001

Prepared by

yogan pillay
john bennett
Celicia Serenata
Bennett Asia

Design & layout

cathleen fourie
the equity project

CONTENTS

Foreword & acknowledgements

It has been often repeated that HIV/AIDS is the biggest and most difficult problem currently facing developing nations and their health systems. While much has been done, much more remains to be done. This publication attempts to fill one small gap in the fight against HIV/AIDS.

Many health district managers and others working at district level have noted the lack of a document that draws together the various HIV/AIDS activities that can be undertaken at this level to ensure coherent implementation. In addition, given that most of us are overwhelmed by the magnitude of the epidemic, easy to implement interventions with some promise should be our first line response especially in the face of scarce resources. It is for this reason that we produced this little booklet with some ideas of what can be done at district level. We have included a few examples of what other countries and districts have tried to illustrate that successful interventions are possible.

Besides the primary authors, many others have contributed to this publication. We wish to thank, in particular, Dr Nono Simelela, Ms Nomvula Marawa and Dr Dave McCoy their support and advice, Ms Ileana Fajardo for editing and Ms Cathleen Fourie for design and layout.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ATICC	AIDS Training and Information and Counselling Centres
CBO	Community-based Organisation
CHW	Community Health Worker
CADRE	Centre for AIDS Development Research and Evaluation
DOTS	Directly Observed Treatment Short Course
DHS	District Health System
HIV	Human Immunodeficiency Virus
HTA	High Transmission Area
HAST	HIV/AIDS/STI/TB
IDP	Integrated Development Programme
IEC	Information, Education, Communication
INP	Integrated Nutrition Programme
MTCT	Mother-to-Child HIV Transmission
MCWH	Maternal, Child and Women's Health
NGO	Non-government Organisation
NAPWA	National Association of Persons Living with AIDS
NACOSA	National AIDS Consortium of South Africa
PWA	Persons Living with AIDS
SANCA	South African Centre for Alcoholism
STI	Sexually Transmitted Infection
SAP	South African Police
SANDF	South African National Defence Force
SANCO	South African National Civic Organisation
TANESA	Tanzania Netherlands Project of Support AIDS centre in Mwanza Region
TB	Tuberculosis
VCT	Voluntary HIV Counselling and Testing

A district-based hiv/aids approach : A visual picture

The following pictures are meant as a visual stimulus
to consider a district as a whole - the different
sorts of community, urban and rural, and
the different sorts of networks
Of youth and adults.

ENVIRONMENT AND HUMAN ECOLOGY

(Varied within a district and between districts)

Tourism and high transmission times and places.

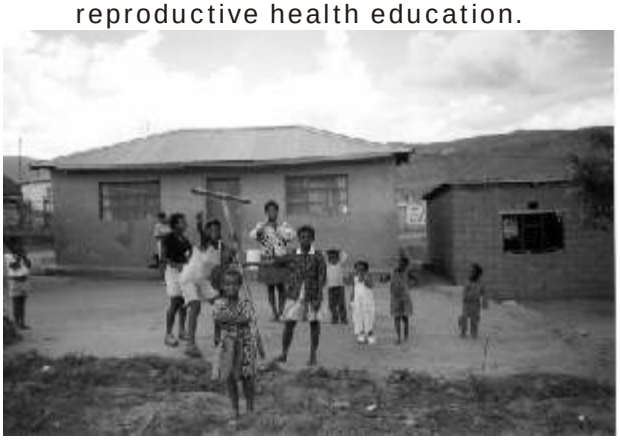
Peri-urban informal settlements.

Arid sheep farming areas with very slow density scattered population and small towns.

Areas with rural villages and migrant male population.

Emphasis on school children and Local media and methods

Children and adolescents form a large proportion of the population. They need life skills, sexuality and reproductive health education.



School learners conveying an HIV/AIDS message through drama.

In all areas radio is important and there might even be, in some districts, local community radio or other forms of communication such as newspapers in the local language.

Person to person interaction and adult behaviour in high transmission areas

Alcohol distribution is an important source of income, and brings people together especially in vulnerable or high transmission areas. Alcohol outlets provide opportunities but also for disease transmission, education, condom distribution.

The need for a good programme

Death, the cold reality of AIDS; however deaths rates by age and sex are seldom known. Each death could be delayed or made more peaceful; but all have consequences for the family.

It is often argued that a top-down approach to the implementation of any strategy is likely to fail or not produce the optimal result for a number of reasons. While top-down approaches have some advantages, they also have disadvantages. We propose that in addition to the current strategies being used by the Department of Health, each district must plan to increase the impact of current intervention strategies based on its own realities. These realities may be historical, demographic, economic, environmental or cultural and behavioural. Such planning has been shown to be effective in countries such as Uganda, Tanzania (TANESA, 1996) and Brazil (Ministry of Health, Brazil, 2000).

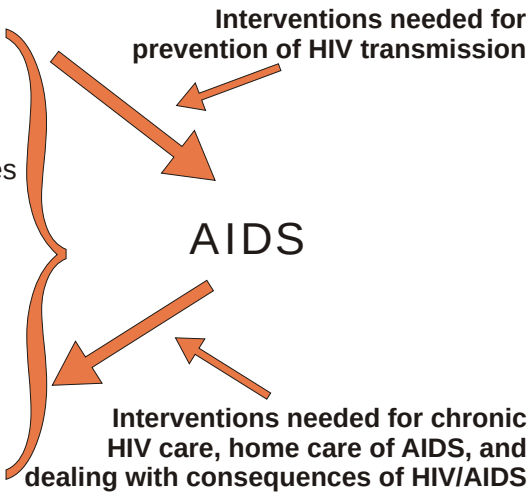
WHY A DISTRICT-BASED APPROACH TO HIV/AIDS?

The decision by the Department of Health to use the health district as the vehicle to render primary health care is based on the assumption that small geographic areas with decentralised management are more likely to ensure that intervention strategies that meet local needs are implemented successfully. In addition, it is likely that local participation and accountability will be greater than in a more centralised system. It is acknowledged, however, that this does not happen by magic - plans, resources and support must be mobilized to ensure effective implementation

Health districts are also more amenable to intersectoral collaboration, particularly other service departments also use the district approach to service delivery. Intervention strategies for HIV/AIDS require the collaboration of the other government departments such as Education (schools and institutions of higher learning), Welfare/Social Development (home-based care and care for AIDS orphans), Labour (workplace health and safety), and Agriculture (food security), etc. In addition, it requires the active participation of non-government organisations (NGOs) and Community-Based organisations (CBOs), the private sector, faith-based organisations, youth and women's organisations, local politicians and traditional leaders. Figure 1 below illustrates that a developmental approach to Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) is imperative given the various factors that impact on its incidence.

Figure 1: Factors impacting on HIV/AIDS transmission and prevalence

- Movement of people
- Disrupted families
- Lack of community recreational spaces and activities
- Overcrowding
- Disempowerment of women
- High unemployment
- Abuse of alcohol and drugs
- Poverty and malnutrition
- Lack of appropriate and adequate health care
- Child development



Note that the factors listed in Figure 1 set the stage for HIV transmission and AIDS and AIDS, in turn, leads to or aggravates those factors.

Some of the essential features of the district model are currently being used by the tuberculosis (TB) programme to increase the efficiency of the Directly Observed Treatment Short Course (DOTS) approach, and by the integrated nutrition programme. Furthermore, they are being proposed by the integrated management of childhood illnesses programme. It is therefore proposed that a similar strategy be used to tackle the HIV/AIDS epidemic at local level. If anyone of the other programmes is being implemented in a particular district then a coordinated effort between the programmes must be considered. Another locus of co-ordination could be the health promoting schools initiative that has already gained acceptance in South Africa.

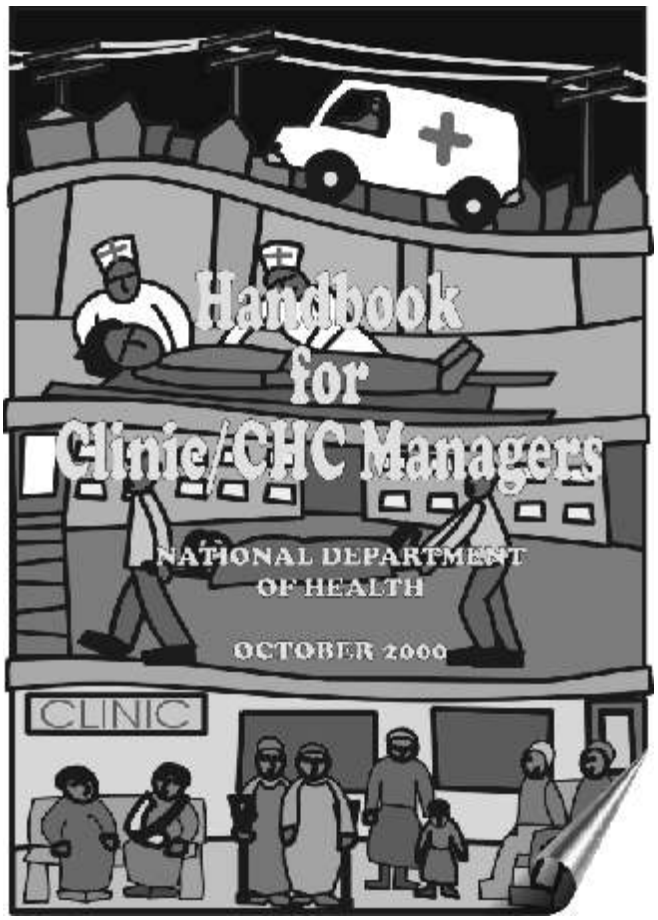
In summary, the reasons for an HIV/AIDS strategy at district level include:

- local issues and problems can be more easily identified and prioritiZed;
- communities may be more easily mobilised around their issues;
- interventions can match the local problems;
- intersectoral collaboration and partnerships with the private sector may be easier to achieve; and
- a "Continuum of Care" for HIV infection and AIDS can be established through a local network of services.

It should be pointed out, however, that the support of provincial and national government is essential to make such a strategy functional.

PLANNING A DISTRICT-BASED STRATEGY

In a document prepared by Tanzania Netherlands Project of Support AIDS centre in Mwanza Region (TANESA) for the National AIDS Control Programme of Tanzania it was proposed that a district-based HIV/AIDS strategy for prevention of HIV transmission should contain 10 components: situation analysis; resource mobilisation and programme development; community interventions; school-based services; work-based programme; sexually transmitted infections (STIs) control; training of health workers; gender issues; development of health education materials; and ensuring safe blood supplies.



Ng'weshemi and Bennett (1997) suggest 5 steps to the establishment of a district-based approach which would extend through prevention of HIV transmission to AIDS care. These are:

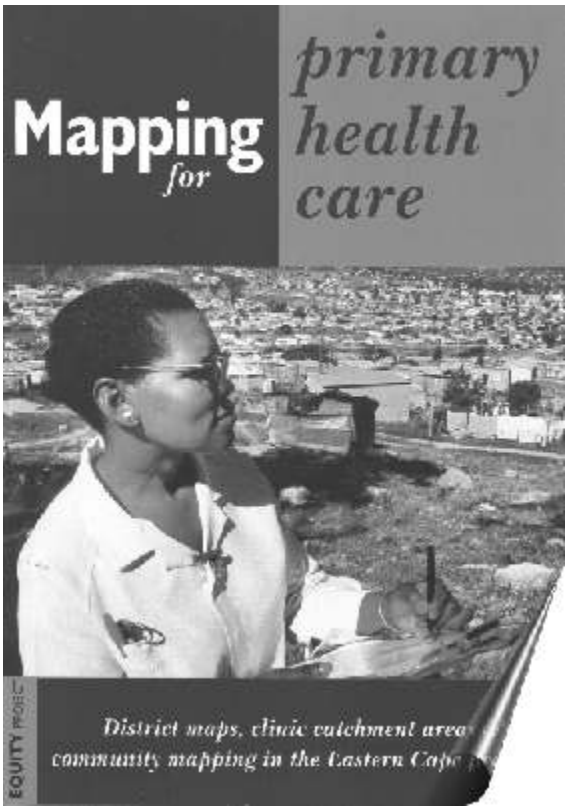
- situation analysis;
- development of a planning structure and process;
- creation of an annual action plan;
- implementation; and
- monitoring and evaluation.

These could be considered generic components of any intervention strategy and should, by now, be part of all district-planning processes in South Africa. It should not be difficult, therefore, to link planning for HIV/AIDS to the generic district planning processes. These generic planning processes are described in material already distributed by the National Department of Health (e.g., the District Manager's Handbook and the planning guide for district management teams).

Many South African health districts have already conducted situation analyses. These may need to be updated and the specific issues relevant to HIV/AIDS may need to be included. A situation analysis should cover the following:

- population (number and density) of the health district by age and gender;
- extent of movement of people within and between health districts;
- epidemiological profile of the population (including prevalence rates of HIV/AIDS, STIs, TB);
- audit of facilities and services (including finances and personnel) provided by health and other service providers (public, private, NGO/CBO, faith-based etc);
- audit of meeting places, e.g., schools, clubs, hotels/hostels, shebeens, shops, churches, truck stops, etc; and
- survey of commercial sex work and sexual/reproductive behaviour and condom distribution and use (include documentation of people with surplus cash and those who are reliant on selling sex for cash the relationship between relative wealth and poverty).

There are two recent publications that illustrate methods which are useful when conducting a situational analysis. These are 'How to conduct a rapid situation analysis for a health district' published by the Initiative for Sub-district Support's and the EQUITY Project's 'The Use of Mapping for Primary Health Care: clinic catchment area maps'.



Ng'weshemi and Bennett (1997) propose two ways of planning an implementation strategy for HIV/AIDS:

- formation of a small planning team; or
- hosting a district-wide AIDS planning workshop.

These approaches need not be mutually exclusive. One can use both approaches or ensure that the regular district planning process includes a specific focus on HIV/AIDS. In addition, every district should have established a District AIDS Council that relates to the Provincial AIDS Councils. Guidelines for the establishment of the District AIDS Council have already been provided to provinces and many are in the process of establishing these structures.

Districts may wish to prioritise areas of the district for urgent and immediate attention. An approach advocated by Luhamba et al (1997) is the selection of high transmission areas within health districts (this may be the first step following the situation analysis and is one way of prioritising intervention). High-transmission areas may include: trucking routes and stops; taxi ranks, and train stations; areas in which commercial sex workers operate; areas of high economic activity (e.g., shopping malls, markets, mining

areas); and areas with large numbers of migrant workers or movement of people. It should be stressed, however, that these should be determined on the basis of the situation analysis conducted by district personnel. At present, there are several high transmission area projects in the country. Results from these projects, and the processes used in establishing them should be shared with other districts.

BASKET OF HIV/AIDS INTERVENTIONS AT DISTRICT LEVEL

The basket of HIV/AIDS services to be rendered nationally is outlined in the HIV/AIDS and STI Strategic Plan for South Africa, 2000-2005 that was released by the Department of Health in 2000. The primary goals of the national strategy are to: (a) reduce the number of new infections especially among the youth; and (b) reduce the impact of the disease on individuals, families and communities. The strategy also outlines 4 priority areas and 14 goals listed in the table below:

Table 1: Priority areas and goals of the national HIV/AIDS strategy

Priority Areas	Goals
1. Prevention	1. Promote safe and healthy sexual behaviour. 2. Improve the management and control of STIs. 3. Reduce mother-to-child HIV transmission. 4. Address issues relating to blood transfusion and HIV. 5. Provide appropriate post-exposure services. 6. Improve access to voluntary counselling and testing.
2. Treatment, care and support	1. Provide treatment, care and support services in health care facilities. 2. Provide adequate treatment, care and support services in communities. 3. Develop and expand the provision of care to children and orphans.
3. Research, monitoring and evaluation	1. Ensure AIDS vaccine development. 2. Investigate treatment and care options 3. Conduct policy research 4. Conduct regular surveillance
4. Human and legal rights	1. Create a supportive and caring social environment. 2. Develop an appropriate legal and policy environment.

Even though a national strategic plan exists, frontline health workers are often unsure how these strategies can be translated into local action. It would be useful to provide clear guidelines for health workers to use. These guidelines should be simple to use and health workers (and others e.g., community health workers, social workers and teachers) should be adequately trained and equipped to implement these guidelines. It is critical that the network of care, from families and communities through to tertiary care, be carefully developed to ensure that continuity of care is provided for all stages of the disease.

Guidelines should be developed for all levels of care including those that will be applied at district level, including:

- Prevention and promotion, including condom distribution and voluntary counselling and testing;
- Care and support for those with AIDS, their families and AIDS orphans; and
- Referral to appropriate services for those in need of secondary and tertiary care.

Guidelines should also focus on STI and TB control. In developing guidelines national and provincial departments of health should be mindful of the variation at district level. Guidelines should be drafted in ways that allow for flexible use. In addition, national and provincial levels should make resources available to support districts to implement the guidelines. Such support may include technical assistance, the provision of more nurses and doctors and equipment, supplies and materials. Given that effective interventions for STIs and TB are available every effort should be made to ensure that these programmes are supported.

The feasibility of integrating HIV/AIDS interventions into all other programmes should be explored, e.g., the inclusion of HIV interventions into reproductive health services at district level. This has been done in other countries, for example, family planning programmes in Mexico and Colombia appear to have successfully integrated AIDS prevention into their marketing and media programmes without negatively affecting their family planning programmes (Aitken, 1999).

Each district should plan for the implementation of voluntary HIV counselling and testing. This includes ensuring that the necessary facilities and trained staff are available within the district.

Every opportunity to strengthen intersectoral action should be maximised. In addition, the importance of an effective communication strategy cannot be underestimated. District and facility managers must ensure that the basket of services to be provided is jointly conceived and rendered by stakeholders such as: traditional and religious leaders; traditional healers; employers, labour organizations; women's and youth organizations; and others.

The link of the health district with the newly defined municipalities and the adoption of the integrated development planning (IDP) approach by municipalities should be used to ensure maximal intersectoral co-ordination at municipal/district level. Each municipality will be expected to develop IDPs and submit these to the province. This approach should ensure that planning between these levels of government are more coherent. It requires, however, that provincial department of health officials work with their local government counterparts and that the same occurs at municipal/health district level the same occurs.

In terms of national policy, there is a range of services that could be offered at district level. These include:

- Community and home-based care (e.g., hospice care)
- Voluntary HIV counselling and testing (VCT)
- Syndromic management of STIs
- Mother-to-child HIV transmission (MTCT) pilots
- Treatment of opportunistic infections
- High Transmission Area (HTA) projects
- Condom distribution
- Directly Observed Treatment-Short Course (DOTS) for tuberculosis
- Through the Department of Education and with Department of Health participants a health programme in primary and secondary schools with peer education.
- Integrated nutrition programmes (INP)

The following table lists the menu of possible activities that can be undertaken at district level and the possible list of organisations and sites that may be partners.

Table 2 : Activities, organisations and sites for a district-based HIV/AIDS programme

ACTIVITIES	SITES/PARTNERS
Health promotion (IEC)	Educational institutions, health facilities, community based organizations, religious institutions, recreational spaces such as taverns, prisons, military camps, traditional healers, community radio and local press
Community & home based care	CBOs/NGOs, CHWs, youth and women's groups; hospices
VCT	Health facilities, private GPs, NGOs/CBOs
HTA	NGOs/CBOs, Dept of Transport, religions institutions, taverns, bars, commercial sex workers, employment generation schemes
MTCT	Health facilities
DOTS	Health facilities, CHWs, traditional healers; prisons, volunteers, private GPs
INP	Dept of Agriculture, health facilities, NGOs/CBOs, employment generation schemes
Treatment of opportunistic infections	Health facilities, private GPs
Condom distribution	Shops, institutions of higher learning, health facilities, traditional healers, youth and women's groups, workplaces
STIs	Health facilities, private GPs, traditional healers, workplaces

Note: health facilities implies both private and public facility providers.

As stated above, health district development in South Africa is closely linked with municipalities. Every attempt must be made to ensure that local government is involved in the development and implementation of a district-based HIV/AIDS programme. Such involvement must, at minimum, include the role of AIDS Training Information and Counselling Centres (ATICCs) and municipal clinics and be incorporated into the integrated development plans of municipalities. The multi-factorial nature of HIV/AIDS will be better addressed through such a developmental process.

Once the district plan is developed in collaboration with all stakeholders indicators should be developed to ensure monitoring and evaluation of the implementation of the plan. The national strategic plan proposes a list of indicators that may be used to monitor HIV/AIDS and STI activities. Table 3 outlines the set of indicators proposed by the strategic plan:

Table 3: Indicators as proposed by the HIV/AIDS and STI strategic plan, 2000-2005

Area	Indicators
General trends of the epidemic	• Prevalence of HIV amongst antenatal clinic attendees.
Youth	• Prevalence of HIV amongst antenatal clinic attendees below the age of 18 years. • Teenage pregnancy incidence and rate.
Prevention	• Proportion of STI cases effectively managed using syndromic treatment in the public and private sectors. • Percentage of sexually active women using condoms. • Proportion of children leaving primary school who are fully informed of the cases and methods of transmission of HIV.
Pre-disposing socio-economic factors	• Proportion of households living below the minimum poverty line. • Unemployment rate.
Abuse of women	• Number of rape cases reported. • Number of cases of workplace legislation abuse related to employees contracting HIV.
Social values, human rights, and acceptance in the community	• Number of VCT clients. • Number of homeless children as proxy indicator of the capacity of society to care for AIDS orphans. • Number of people 'coming out' as people living with AIDS.

The list provided in the table above could be used as a guide by districts to develop their own set of indicators that can be used at this level. Lydenburg district in Mpumalanga has adopted seven indicators to monitor their HIV/AIDS plan (see below for details). Another possible list of indicators for districts may include:

- Per capita expenditure on HIV/AIDS prevention (compared to province and national average);
- Total expenditure per capita for HIV/AIDS (compared to provincial and national average);
- Condom availability (number of condoms distributed/population between 15-49) per month, quarter, year;
- List of number of outlets providing condoms (private and public);
- STIs (number treated/expected infections) in last month, quarter, year;
- Number of school children exposed to AIDS education in last month, quarter or year/total number of school children in district;
- Number of out-of-school children exposed to AIDS education in last month, quarter or year/total number of out-of-school children in district;
- Number of adults exposed to AIDS education in last month, quarter or year/ total number of adults in district (19 -49 yrs); and
- District HIV/AIDS plan in place and activities monitored.

The importance in having and using a list of indicators however, is not the list per se but the use of the data and information for management. It is also important to involve stakeholders in determining indicators and to facilitate their use of the data for reviewing plans and implementation strategies.

ENLISTING LOCAL LEADERSHIP

A district health office should know exactly not only the location of all the clinics, health centres and hospitals but also their catchment area and its population. Each clinic may have a community health committee made up of leaders from communities in the clinic's catchment area. Each health centre and hospital typically has a board. Bigger areas such as a town may have a health forum. The Department of Education has similar entry points to community leadership through the school governing bodies. The civic organisations also have leaders from local areas.

All of these structures in a district may, however, require activation and mobilisation for HIV prevention and AIDS care. Together with the District AIDS Councils, which all districts should establish, the District Health Management Team has a critical role to play in mobilising community structures to be advocates for the HIV/AIDS programme in the district.

ROLES OF PROVINCIAL AND NATIONAL DEPARTMENTS

The roles of the national and provincial departments, in support of health districts must be clearly established. Both national and provincial departments should provide clear guidelines and technical support to districts. The National Department of Health has developed a series of policies and guidelines to assist facilities to render care to those infected and affected with HIV/AIDS. These include:

- Management of occupational exposure to the human immunodeficiency virus (HIV);
- Prevention of mother-to-child HIV transmission and management of HIV positive women;
- Policy guideline and recommendation for feeding of infants of HIV positive mothers;
- Ethical considerations for HIV/AIDS clinical and epidemiological research;
- Recommendations for the prevention and treatment of opportunistic and HIV related diseases in adults;
- Tuberculosis and HIV/AIDS clinical guidelines;
- Rapid HIV tests and testing; and
- Recommendations for managing HIV infection in children.

Technical support from provinces must be provided in a targeted manner and in response to clearly identified needs by the district. The role of the national and provincial departments of health can be strengthened by:

- Streamlining the activities of the national and provincial AIDS units to ensure more co-ordinated and targeted support to provinces and health districts;
- Greater co-ordination between programmes such as HIV/AIDS, TB, MCWH, and the human resources, health promotion and planning units at provincial level;

- Greater role clarity among personnel at provincial, regional and district levels to eliminate overlaps and gaps in implementation; and
- Greater intersectoral co-ordination at national and provincial levels.

National and provincial departments also have the responsibility of assisting in monitoring and evaluation of the implementation of policies and guidelines and for sharing of best practices with other districts. The national DHS competition has been used as one way of evaluating the HIV/AIDS activities of health districts and of sharing lessons. For the first time, in 2000 districts were assessed with respect to their HIV/AIDS activities and a national prize was awarded to the district with the best HIV/AIDS programme awarded to Lydenburg. We need to build on such activities in ways that strengthen districts and improve service delivery.

Often IEC materials are developed nationally and have limited relevance for many settings. It is important that districts, together with NGOs, are empowered to develop IEC materials that are relevant and appropriate for their contexts. Both national and provincial levels should play a role in ensuring that local variation does not lead to the production of contradictory, confusing and inaccurate messages.

Establishing a district based hiv/aids and stl programme: five simple steps

- Determine extent of the problem using relevant tools (e.g., mapping) with stakeholder involvement;
- Determine goals and objectives for the year in line with national and provincial priorities;
- Develop an implementation plan in line with available resources, including trained personnel;
- Ensure that all relevant personnel have access to the policy documents and clinical guidelines; and
- Determine list of indicators to be used to monitor and evaluate interventions.

LESSONS FROM A FEW INTERNATIONAL AND NATIONAL EXPERIENCES

Brazil

In 1994 the Ministry of Health in Brazil decided to decentralise the HIV/AIDS and STI programmes to health districts. Three years later an external evaluation of HIV/AIDS found the following:

- The decentralisation of HIV/AIDS and STI activities to district level required national level support;
- Efficiency of the model depended on contracts between government at different levels;
- Political goodwill enjoyed by the health ministry was important;
- The strategy must be effectively monitored;
- There are risks in financial transfers to the periphery but the benefits are greater and likely to be sustainable; and
- The development of management capacity in such areas as planning, monitoring and assessment are critical to the process (Ministry of Health, Brazil, 2000).

The Brazil experience is instructive as it suggests that there is a relationship between district development broadly and a programme, in this case HIV/AIDS. Many of the issues raised by the evaluation are challenges with which the South African health system is currently confronted. A particularly important insight from the Brazil experience is the issue of financial transfers to the periphery: if the bulk of the effort is at district level then the resources must be made available to ensure that the work can be done

UGANDA: RAKAI DISTRICT

One district in Uganda has a well-known history of turmoil and a consequent escalated AIDS epidemic. This is the Rakai District in the South Western part of Uganda which shares a boundary with Tanzania and also borders Lake Victoria. In 1978, President Idi Amin invaded and annexed Tanzania's Kagera Salient adjoining the Rakai District. Tanzania forces invaded Uganda in early 1979 and joined with Ugandan rebels in taking Kampala and defeating Ugandan and Libyan units. This area therefore had a background of Ugandan, Tanzanian, Libyan and rebel forces moving through. It also had major truck routes to Tanzania and to Rwanda passing through the district. It had landing sites for boats and a history of smuggling across the Lake. The district is populated with dominant tribes of Baganda and Banyankole but is also inhabited by people from Rwanda, Burundi and Tanzania. The population is estimated at over 510,000 with a density of about 100 persons per square kilometre. The majority, 60%, are Catholics. The two sexes are almost equally represented and 96%of the people are rural farmers. The 4% of urban dwellers are in small towns and market centres.

The first AIDS cases (“slim disease”) in Uganda were reported around a lakeside landing area in 1982 and were thought locally to be due to witchcraft. In 1984, the first public discussions were held and in 1986 a major campaign was spearheaded by the president. A multisectoral approach with political, local and religious leaders was started focusing on raising awareness through health education. Soon there was an influx of donors, community-based organizations, NGOs and research projects. A community-based longitudinal study in randomly selected villages showed an HIV prevalence rate of 35% along main roads and 12,6% district-wide. Incidence studies showed 2,4 HIV+ per 100 people (7,0 per 100 in youth age 17-25), peaking in women aged 20-29, earlier than men, 30-39 years.

What has been done

The beginning of the visible epidemic was fortunate to be followed by the reorganization of the districts and the adoption, with the President's support, of a multi-sectoral policy and strategy on AIDS control. Uganda has no regions or provinces and the districts are the focus of implementation. Planning is from the bottom up in districts. Rakai was fortunate in receiving technical and other resources to initiate preventive advocacy, mitigation and research strategies. These are outlined below:

Preventive measures

- The district administration, together with partner NGOs, provide multisectoral school health programmes with peer education and class and group activities (drama and music), sport and youth activities with education, and condom promotion and distribution.
- Community-based activities by the government, CBOs and NGOs have assisted in ensuring awareness of HIV/AIDS leading to behaviour change.
- A call for openness by local leaders and political and religious leaders accompanied by the provision of support for HIV/AIDS affected people has led to diminished stigma.

- Voluntary counselling and testing (VCT) is offered in all major government health units in the district. HIV tests were initially charged for but are now free.

Care and support

- In all health units care and support including treatment of opportunistic infections is offered. Health units have outreach programmes for home visits.
- Orphanage centres have been established by NGOs.
- Many NGOs have started income generating activities (agricultural support, youth skills training, micro financing) to enable those with HIV/AIDS and their dependants to support themselves.
- Many women's programmes aim at creating awareness about rights, inheritance, domestic relations laws and economic empowerment and these have been done district-wide with assistance from international organizations.
- Resettlement of orphans through adoption, fostering and relative tracing mechanisms. In addition, a computerized database has been established on children vulnerable as a result of HIV/AIDS.

Research

- In 1989 the first community-based survey of HIV and its dynamics was conducted by the Rakai Project in 21 randomly selected villages. This longitudinal cohort study is still continuing and is a collaborative project between the Ugandan Virus Research Institute, Ministry of Health, Makerere University, and Columbia and Johns Hopkins Universities
- A study on sexual networks and behaviour has been conducted.
- STI control and AIDS prevention studies were conducted which concluded that the population attributable fraction of incident HIV associated with classical STIs (syphilis, trichomoniasis, gonorrhea, chlamydia) is 15 16%. Complete treatment coverage of all symptomatic persons might reduce transmission of HIV by a maximum of 10% in Rakai.
- Preparation for AIDS vaccine evaluation.
- A research organization, Participatory Action Research (PAR) based in the town of Lyantonde is looking at socio-cultural determinants of transmission using participatory research to empower the community to cope with the epidemic and to become part of the solution for reduction of HIV/AIDS and its impact.

Results of activities and interventions

The table below illustrates the results of the various interventions

	PREVALENCE	1998 PREVALENCE
HIV	12.6% (1989)	9,2%
Syphilis	10% (1994)	6,2%
Genital Ulcer	8,9% (1994)	5,7%
Trochomoniasis	24,3% (1994)	11,6%

- Consistent use of condoms however remains low at < 4%.
- There is universal awareness of HIV transmission and major preventive measures

What is the district's infrastructure?

- There are 5 district hospitals and 4 levels .
- Level 1 is largely a visit by a mobile clinic or is a satellite room with perhaps a community health worker. Level 2 (HC 2) is at parish level and there are 25 of these with a midwife and comprehensive nurse. Level 3 (HC 3) at sub-county level 19 have a clinical officer, midwife, 3 nurses and a health assistant. Level 4 (CH 4) at county level with a medical officer, laboratory, theatre nurses and midwives.
- All units are providing services in relation to HIV/AIDS and have the possibility to refer appropriately to and from along a continuum of care with the community-based, non-government organizations, church-based institutions and research centres.
- Transport away from main routes is often limited to motorcycle, bicycle or foot.

Conclusions and lessons from Rakai District

Rakai, off course, is a special district due to its history, the excess of donors, experts and research activities. It is however, still a poor rural district with problems like any other district but it is getting on top of its HIV/AIDS/STI epidemic, so there are lessons to be learned. These are:

- The importance of political will to integrate all sectors for planning and implementation and to publicly recognize the need for openness in dealing with AIDS. The use of political, civic, and church hierarchies within a district to cascade information down to family and community level. (The leaders in these institutions have been trained).
- Use of all public awareness mechanisms: radio, the press, drama, public meetings, market day meetings.
- Having a district medical officer with epidemiological skills in charge of relevant aspects and a district manager manages the health services.
- Having in every health unit an HIV/AIDS/STI/TB programme of activities which are part of a known continuum of support and care based on church, CBO and NGO activities in the district. (It is preferable to have a district referral guide to all agencies working for HIV prevention and AIDS care).
- The importance of voluntary testing and counsleling as a preventive measure. This depends mostly on the quality of post-test counselling; counsellors must be specially trained on how to counsel an HIV+ person to keep living positively and remaining well and not transmitting the infection; and on how an HIV- person can remain negative for the rest of her/his life. There are post-test clubs, which provide continuing peer support and companionship free from possible stigma.
- Increased use of PWA (persons living with AIDS) to visit schools for discussions, participate in meetings and workshops and who themselves form NGOs or CBOs e.g., NACWOLA for women living with AIDS.
- Centres that provide VCT also provide a more comprehensive and integrated service; do RPR at same time as HIV tests, and have full reproductive health and TB services available.
- Start the use of antiretrovirals as soon as prices and management can make it available nevirapine for prevention of mother to child transmission and generic antiretroviral therapy in hospitals.

- Emphasize for youth the dangers and early sexual debut, multiple new partners, partners of a different age group, the importance of abstinence and secondary abstinence after an indiscreet start.
- Set up programmes with traditional healers. This requires training and working together with mutual respect.
- Continue to work on improvement of quality of care in all health facilities, especially for HIV/AIDS/STI/TB services..
- Provide services for children affected by HIV/AIDS.
- The final lesson learned is about the poverty and devastation that AIDS produces: the orphans, the child-headed homes, the failure in agriculture, and the increasing prostitution. This needs a multi-sectoral approach to development. Social welfare/development has a special role in arranging care for orphans and the destitute. Income generating activities are needed but group ones often fail and skill training and loans for individuals proved more viable in Uganda. In Rakai the process of decentralization to counties and parishes allows for each unit of the district to plan for its needs and by having these plans come together at district level allows for co-ordination and ensures equity in the allocation of financial and other resources.

Tanzania

By 1996, almost every family in Tanzania had seen or heard of at least one member of their extended family being affected by HIV/AIDS. The National AIDS Control Programme realized that the number of cases would increase in the future if preventive activities were not undertaken. Money, time, and resources had to be invested in reducing HIV infection transmission realizing that more resources would also be needed for the care and the consequences of AIDS. Based on experience in two districts in the northern Tanzania, an internationally-funded project prepared a district-based HIV/AIDS document. This document to which we have already referred (TANESA 1996) laid out five conditions for HIV/AIDS programmes: multisectoral commitment, integration into overall planning and development, community participation, resource mobilisation, and prioritisation and long-term planning. Specifically the document addressed HIV prevention and not AIDS care; for each of its 10 components it listed objectives, strategies, activities and resources needed and estimated costs; it also made reference to useful manuals, guidelines and documents. Emphas was placed on a budget needed to ensure preventive activities because the budget for care activities would increase rapidly in the future.

South Africa

- **Eastern Cape (HAST)**

  In the Eastern Cape Province district-based HIV/AIDS implementation has witnessed the development of innovative activities and intersectoral linkage. Port Elizabeth/Uitenhage/Despatch, now a metropolitan area called the Nelson Mandela Metro, has a comprehensive intersectoral programme and a high transmission area (HTA) project covering Walmer and the Central area of Port Elizabeth. In Albany District there is an active HIV/AIDS/STI/TB (HAST) programme which coordinates HAST activities through intersectoral and interagency coordination of a HAST committee.

  One of the modules in a district managers management training programme in the Eastern Cape is called HAST. As part of the course district teams that underwent training developed and undertook a situation analysis integrating the previously separate control programmes. Factors that facilitate STI transmission were reviewed as were those that facilitate HIV

transmission and increases in TB prevalence. The components required for an effective programme, namely: laboratory, information, drug distribution, supervision, training, clinical care, community involvement and resources, were also assessed.

This HAST project has mobilised government sectors and their different departments and community-based organisations and NGOs as well as Rhodes University around preventive, treatment and care activities. It is now preparing to develop a "High Transmission Area Approach" with possible multiple foci (still to be more accurately identified using established tools) in the district which includes a city, and 6 smaller towns with growing informal settlements, a tourist and fishing area on the coast and numerous national and other roads and truck routes, and a variety of different farming areas, some with intensive seasonal activities.

A survey of knowledge, attitudes and behaviour of high school learners has already been undertaken in Grahamstown. The survey has indicated the urgent need to have a more extensive life skills and sexuality programme extending down to primary school level. Box 1 provides more detail on the major areas of work and partners in the Albany District.

Box 1: Albany Health District's HIV/AIDS activities

The Albany Health District HAST Committee

- The Committee reviews the operational plans and activities of all the partners in the district (see major activities and list of partners below).
- At each meeting the Committee reviews information on HIV, STI and TB provided by the District Information Officer and the Communicable Disease Coordinator CDO).

Prevention of HIV/AIDS

- Life skills for Youth (FAMSA & Department of Education)
- Increase access and use of condoms
- Improved management of STI
- Gender Projects
- High Transmission Areas

Treatment, care and support (partners)

- Hospice; Grahamstown Health Forum; St Phillips Care Centre; Department of Welfare; St Johns Foundation; Resource Centre; District Hospital (referral system); PWA Support groups

Mobilization of all sectors and communities

- Department of Health (Health coordinators report; Health Promotion; Male involvement); Department of Education; SAPS; SANDF; Church groups; NAPWA; NACOSA; "Talking Hands" (puppets for health); Department of Correctional Services; Rhodes University; Masifunde Project; CADRE; SANCA; SANCO

Lydenburg District, Mpumalanga

The Lydenburg District's HIV/AIDS programme was considered the best in the country and won the prize for the best HIV/AIDS programme in the National Districts Assessment/Competition in 2000. The following indicators were used to assess the district's HIV/AIDS programme (figures in parenthesis indicate number of points allocated):

- District-based HIV/AIDS Plan (no plan = 0; plan developed, but no input from stakeholders = 1; plan with stakeholder involvement and implemented = 2);
- Percentage of clients/patients who are counselled for HIV/AIDS (0-20% = 0; 21-70% = 1; 71-100% = 2);
- Condom coverage: number of condoms issued in the past month as a percentage of the sexually active population of the district (0-20%= 0; 21-70%= 1; 71-100% = 2);
- Audit of home-based care for people living with HIV/AIDS (no audit = 0; audit done = 1; audit used for planning and referral = 2);
- Provision of home-based care for people living with HIV/AIDS (0-20% = 0; 21-70% = 1; 71-100% = 2);
- Strategies to target groups at risk for HIV/AIDS (no strategy = 0; at least one strategy =1; more than one strategy = 2); and
- Percentage of patients using DOTS (none = 0; less than 50% = 1; more than 50% = 2).

The above assessment provided no rating of the interventions in schools. There needs to be a specific rating of the Department of Education's, HIV interventions. Life skills and sexuality programmes in both primary and secondary schools are a most important preventive strategy and need emphasis.

The Lydenburg Health District consists of 168 000 people living in 8 towns. The district produced an HIV/AIDS plan based on a situation analysis. The analysis was conducted by a planning group formed in 1998. Key stakeholders including community members, representatives of NGOs and CBOs and personnel from various district level government sectors were involved in the situation analysis and the planning process.

Some of the key features of the Lydenburg District's HIV/AIDS strategy are listed in box 2.

Box 2: Key features of the Lydenburg Health District's HIV/AIDS plan, 2000

Aim:

- To reduce HIV transmission and to promote AIDS care
- To achieve behavioural change to prevent HIV transmission
- To alleviate suffering and prolong and improve the quality of life for those affected by AIDS

Objectives:

- To reduce HIV transmission amongst adolescents in high transmission areas
- To prevent partner changes and to introduce STD control using the syndromic approach
- To diminish stigma and discrimination against HIV patients
- To focus on interventions such as safe sex with condom use and increase knowledge and change attitudes of adolescents

Activities:

- Conduct workshops on Syndromic Management of STDs
- Improve STD surveillance including contact tracing slips in all clinics and CHCs
- Develop policies and protocols for needle sticks, pregnancy, condoms for private providers
- Implement provincial condom policy and distribute condoms
- Mass media campaign; radio advert on 'safe sex saves lives'
- Organise and participate in World AIDS Day
- Train 20 voluntary peer educators and 20 voluntary home-based care workers in each town
- Establish HTA sites (in areas of high commercial sex worker activity)
- Establish working relationship with roleplayers re: life skills
- Train AIDS counsellors in the district
- Monitor and Support NGO activity

Achievements - December 2000:

- 304 community volunteers recruited and trained
- HTA at Strijdom Tunnel launched
- 7 peer education projects launched
- 304 000 condoms distributed per month
- 5 schools involved in health promoting schools initiative
- 137 traditional healers trained
- 25 AIDS counsellors trained

CONCLUSION

From the few examples presented above, it is clear that much progress can be made if a coherent programme of action is developed and implemented. What are the key ingredients of a successful district based HIV/AIDS strategy? They are:

- Political leadership at all levels;
- Decentralisation of HIV/AIDS activities that are supported and monitored by provincial and national levels;
- Clearly defined roles of national and provincial health departments must be clearly defined;
- District level experiences can be used to develop national and provincial policies (the bottom-up approach); and
- District-based planning and implementation should ensure that all stakeholders are consulted and participate in the HIV/AIDS programme.

REFERENCES

- Aitken, IW. 1999. Implementing and integrating reproductive health services in a decentralised system. In R-L Kolehmainen-Aitken (ed.) Myths and Realities about the Decentralization of Health Systems. Management Sciences for Health: Boston.
- Department of Health 2000. HIV/AIDS and STD Strategic Plan for South Africa, 2000-2005. Department of Health, Pretoria.
- Department of Health 1999. Recommendations for managing HIV infection in children. Department of Health, HIV/AIDS Directorate, Pretoria.
- Department of Health Prevention of mother-to-child HIV transmission and management of positive pregnant women (enacted in terms of the National Policy for Health Act, 1990).
- Department of Health 1998. Policy guideline and recommendation for feeding of infants of HIV positive mothers (Prepared for the HIV Transmission and Breast Feeding Task Group by Dr Clive Evian, Policy Consultant, HIV/AIDS & STD Directorate, Department of Health).
- Department of Health 2000. Ethical Considerations for HIV/AIDS Clinical and Epidemiological Research.
- Department of Health 2000. Recommendations for the prevention and treatment of opportunistic and HIV related diseases in adults.
- Department of Health 1999. Tuberculosis & HIV/AIDS - Clinical Guidelines.
- Department of Health 1999. Rapid HIV Tests and Testing.
- Department of Health 2000. Recommendations for managing HIV infection in children.
- Luhamba, D, Schapink, D and Msuya W. 1997. Community level interventions. In J Ng'weshemi, T Boersma, J Bennett, D Schapink (eds.). HIV prevention and AIDS care in Africa: a district level approach. Royal Tropical Institute, Amsterdam.
- Lydenburg Health District (2000) Strategic Planning STD/HIV/AIDS.
- J. Ng'weshemi, and J. Bennett, 1997. Development of a comprehensive district HIV prevention and AIDS care programme. In J Ng'weshemi, T Boersma, J Bennett, D Schapink (eds.). HIV prevention and AIDS care in Africa: a district level approach. Royal Tropical Institute, Amsterdam.
- Ministry of Health, Secretariat for Health Policies, National Co-ordination for STD and Aids Brazil. 2000. The Brazilian Response to HIV/AIDS: Best Practices. Brazilia DF.
- Pillay Y, Mzimba M and Barron P. 1998. District Manager's Handbook. Department of Health, Pretoria.
- Pillay Y. 1999. Health Planning for District Management Teams. Department of Health, Pretoria.
- TANESA. 1996. Planning of district HIV/AIDS programmes: components, conditions, contents and costs. TANESA for NACP, Tanzania.

The EQUITY Project, South Africa Nursing Council Building
3rd Floor, 602 Pretorius Street, Arcadia, Pretoria
PO Box 40394, Arcadia, 0007, South Africa

Telephone: +27 (0) 12 344 6117
Facsimile: +27 (0) 12 344 6115
Email: publications@equityproject.co.za
Website: www.equityproject.co.za

ACKNOWLEDGEMENT AND DISCLAIMER

The EQUITY Project is a project of the Department of Health funded by the United States Agency for International Development (USAID)/South Africa through Management Sciences for Health (MSH).

This report was made possible through support provided by USAID under the terms of contract 674-0320-C-00-7010-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of USAID or MSH.

Coral Print cc Tel: 043 743 5573 JN22504ER